

Confidential Medical & Dental History for a Minor Patient

Today's Date: _____

Patient Name (first, MI, last): _____ Date of birth: _____

Medical History (Please circle Yes or No for each)

1. Physician's name: _____ Physician's phone: _____
2. Date of last medical examination? _____ Weight: _____
3. Patient is in good health? Yes / No If no, why? _____
4. Patient has regular medical exams? Yes / No
5. Patient is under the care of a physician at this time? Yes / No If yes, why? _____
6. Patient is up to date with immunizations? Yes / No
7. Patient is presently taking medications? Yes / No If yes, what and why? _____
8. Patient has allergies (medications, food, latex/rubber)? Yes / No If yes, what? _____
9. Patient has been hospitalized? Yes / No If yes, why and when? _____
10. Patient has had any operations? Yes / No If yes, why and when? _____
11. Patient has had general anesthesia? Yes / No
12. If yes, were there any complications? Yes / No If yes, please explain complications: _____

Has the patient experienced, have or had any of the following? (Please circle Yes or No for each)

- | | |
|--|---|
| Yes / No Anemia | Yes / No Heart defects |
| Yes / No Arthritis, rheumatism | Yes / No Heart disease /defects / murmurs |
| Yes / No Artificial prosthesis, organs, joints, implants, shunts, valves | Yes / No Hepatitis |
| Yes / No Asthma | Yes / No High blood pressure |
| Yes / No Blood disorder | Yes / No Jaundice |
| Yes / No Blurred vision | Yes / No Joint pain or stiffness |
| Yes / No Bone pain | Yes / No Kidney or bladder disease |
| Yes / No Canker or cold sores | Yes / No Muscle pain, weakness |
| Yes / No Chest pain, tightness, wheezing | Yes / No Persistent cough or runny nose |
| Yes / No Diabetes | Yes / No Recent significant weight loss |
| Yes / No Diarrhea or constipation | Yes / No Rheumatic fever |
| Yes / No Ear infections | Yes / No Seizures |
| Yes / No Eating disorders | Yes / No Sexual transmitted disease |
| Yes / No Excessive thirst | Yes / No Shortness of breath |
| Yes / No Eye disease | Yes / No Skin disease |
| Yes / No Fainting spells | Yes / No Spina bifida |
| Yes / No Family history of diabetes | Yes / No Stomach problems or ulcers |
| Yes / No Fever | Yes / No Stroke |
| Yes / No Frequent urination | Yes / No Thyroid disease |
| Yes / No Frequent vomiting | Yes / No Transplants |
| Yes / No Headaches | Yes / No Tuberculosis |
| Yes / No Hearing problems, ear pain | Yes / No Tumors or cancer |
| Yes / No Heart attack | Yes / No Urinary tract Infections |

This information will not be released unless specifically authorized by patient.

- | | |
|--|---------------------|
| Yes / No Treatment for emotional, mental, or physical delays | Yes / No Anxiety |
| Yes / No AIDS/HIV | Yes / No Depression |

13. Does the patient have or has he/she had any other diseases or medical problems NOT listed on this form? Yes / No

14. If yes, explain: _____

15. Is there any issue or condition that you would like to discuss with the dentist in private? Yes / No

(dental history continued on next page)

